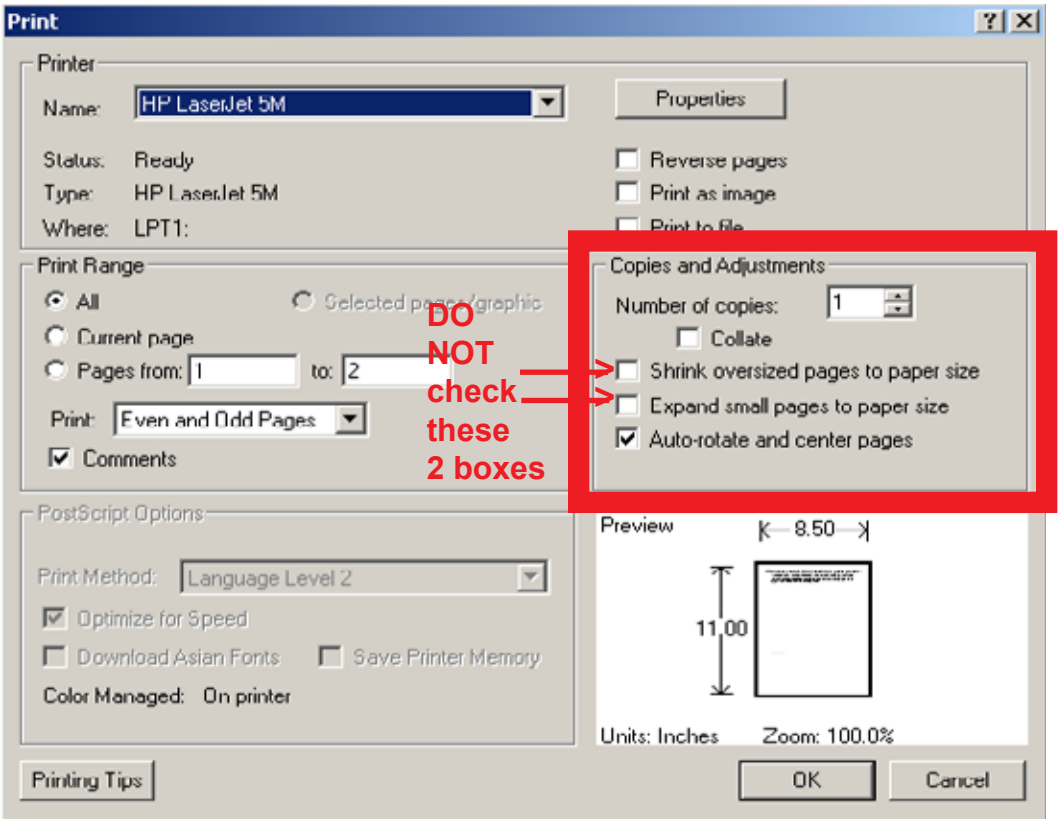
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (REV 3/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Dispensing Optician Apprentice License Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

DOH 647-014 (REV 3/2006)

Dispensing Optician Apprentice

DEPOSIT SLIP

NAME (PLEASE PRINT) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

1F 0260020000 00515

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Washington State
Apprentice-Dispensing Optician
General Information

The apprenticeship program is one of three methods used to gain eligibility to sit for the dispensing optician examination.

An apprentice must acquire a total of 6,000 apprenticeship hours in a minimum of three years and a maximum of six years. This six-year time frame begins once an apprentice is registered and terminates six years later. The apprenticeship will continue without interruption whether the apprentice maintains an active registration or not. After the six-year apprenticeship has expired an apprentice is only authorized to perform the duties of an optician if employed and personally supervised by a doctor, or licensed as a dispensing optician.

To register as an apprentice an applicant should submit a completed application and a non refundable $75 fee made payable to the Department of Health. Send the application and fee to:

Department of Health
Dispensing Optician Program
PO Box 1099
Olympia, WA 98507-1099

Once the application is complete, a registration will be issued. When the applicant receives his or her registration, it must be posted in a conspicuous location where customers may readily view it.

Other licensed opticians, optometrists, or physicians may supervise an apprentice, but the supervisor to whom the apprentice is registered must provide the majority of training. If the apprenticeship training is terminated, a training certificate must be completed by the supervisor and mailed to this office.

When changing supervisors, an applicant may not continue to work as an apprentice-dispensing optician until a new application and $75 fee is submitted, and a new registration is issued. No hours will be accepted under the new supervisor until the applicant is registered under his or her license.

An apprentice may acquire a maximum of 2,000 hours in a 12-month period. A monthly apprenticeship log must be maintained, which records hours accumulated and the period of time covered. Both supervisor and apprentice must initial the log.

When an apprentice has accumulated 6,000 hours (in a minimum of three years) he or she may apply for the dispensing optician examination.

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE #	ISSUANCE DATE

Apprentice Dispensing Optician Application

Credential #

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by applicable fee which is nonrefundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE NAME

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)
( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
— —

GENDER ☐ Female ☐ Male

BIRTHDATE (MO/DAY/YEAR)
/ /

PLACE OF BIRTH (CITY/STATE)

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list other name(s): _____

2. Licensee's Information

SUPERVISOR'S NAME | LICENSE NUMBER

BUSINESS NAME | TELEPHONE NUMBER

BUSINESS ADDRESS

CITY | STATE | ZIP CODE

LICENSED TO PRACTICE AS:

☐ Physician ☐ Optometrist ☐ Dispensing Optician

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. Licensee's Statement

I, _____ , certify that I am qualified to act as an apprentice
Name of Licensee

dispensing optician supervisor and I have read and am familiar with Chapter 18.34 RCW and Chapter 246-824 WAC relating to the training and registration of apprentice dispensing opticians. I understand that direct supervision requires a supervisor to provide the majority of the training and be on the premises 80% of the time while the apprentice dispenses spectacles and 100% of the time while the apprentice adjusts and fits contact lenses. I will record the beginning and ending dates of supervision of this apprentice and maintain a record of total hours worked under my supervision. I understand that I may not have more than two apprentices under my supervision at any one time.

_____ _____
Licensee's Signature Date

5. Apprentice's Attestation

I, _____ , certify that I am the person described and identified in this
Name of Apprentice

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act. I attest that I have answered all questions truthfully and completely and the documentation provided in support of this application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I have not been convicted of any criminal charges and/or suffer from any physical or mental conditions, which would jeopardize the quality of care rendered by me to the public. I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my credential to practice in the State of Washington.

_____ _____
Signature of Apprentice Date

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
Dispensing Optician Program
PO Box 1099
Olympia, WA 98507-1099
(360) 236-4948

Training Certification for Apprentice Dispensing Optician

NOTE: Use this form to **document total apprenticeship training hours** when the apprenticeship supervision has terminated.

Please Type or Print Clearly

Supervisor's Full Name _____
LAST FIRST MIDDLE INITIAL

Business Name _____

Business Address _____

City _____ State _____ Zip _____ County _____

Daytime Telephone Number _____

Licensed to practice as: ☐ Physician ☐ Optometrist ☐ Dispensing Optician

License Number _____

I certify that

(Apprentice's Name), _____

has been under my direct supervision as an Apprentice Dispensing Optician for the period:

beginning _____
MONTH DAY YEAR

and ending _____ and has accrued a total of _____ apprenticeship
MONTH DAY YEAR

hours while under my supervision.

I, _____, certify that
PRINT OR TYPE FULL NAME OF DIRECT SUPERVISOR

I am the person identified above as the supervisor and that to the best of my knowledge and belief the statements made in this affidavit are true and correct.

_____ _____
SIGNATURE DATE

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4948

Dispensing Optician Apprenticeship Log

Supervisor:

Apprentice:

Date		Total Hours	Supervisor Initials	Apprentice Initials
From (MO/DAY/YR)	To (MO/DAY/YR)			

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